



PATIENT REGISTRATION (Child/Adolescent)

Patient Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

☐ Male ☐ Female Age: _____ Nickname: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____

Minor Living With:

☐ Both Natural Parents ☐ Natural Mother ☐ Natural Father ☐ Other _____

School Attending: _____

City: _____ State: _____

Father's Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ AGE: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ AGE: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: _____

Address: _____

Phone: _____ Relationship: _____

Dental Insurance Primary Carrier

Insurance Company: _____

Employee: _____ Date of birth: _____

Group No.: _____ Subscriber ID#: _____

Dental Insurance Secondary Carrier

Insurance Company: _____

Employee: _____ Date of birth: _____

Group No.: _____ Subscriber ID#: _____

1. Are you having pain or discomfort at this time? _____ YES NO
2. Have you been under the care of a medical doctor during the past two years? _____ YES NO
- Physician's Name _____
- Address _____ Telephone _____
3. Are you now taking any medication, drugs or pills? _____ YES NO
- If yes, please list: _____
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? _____ YES NO
- If yes, please list: _____
5. Indicate which of the following you have had or have at present. Please circle and provide date.
- | | | | | | | | | |
|--------------------------|-----|----|-------------------------------------|-----|----|---------------------------|-----|----|
| Heart Failure | YES | NO | Stroke | YES | NO | Hepatitis A (infectious) | YES | NO |
| Heart Disease | YES | NO | Artificial Joints (hip, knee, etc.) | YES | NO | Hepatitis B (serum) | YES | NO |
| Heart Attack | YES | NO | Kidney Trouble | YES | NO | Venereal Disease | YES | NO |
| Angina Pectoris | YES | NO | Ulcers | YES | NO | A.I.D.S. | YES | NO |
| Congenital Heart Disease | YES | NO | Diabetes | YES | NO | H.I.V. Positive | YES | NO |
| Heart Murmur | YES | NO | Thyroid Problems | YES | NO | Cold Sores/Fever Blisters | YES | NO |
| High Blood Pressure | YES | NO | Glaucoma | YES | NO | Blood Transfusion | YES | NO |
| Arteriosclerosis | YES | NO | Cosmetic Surgery | YES | NO | Hemophilia | YES | NO |
| Mitral Valve Prolapse | YES | NO | Emphysema | YES | NO | Anemia | YES | NO |
| Artificial Heart Valve | YES | NO | Chronic Cough | YES | NO | Sickle Cell Disease | YES | NO |
| Heart Pacemaker | YES | NO | Tuberculosis | YES | NO | Bruise Easily | YES | NO |
| Heart Surgery | YES | NO | Asthma | YES | NO | Liver Disease | YES | NO |
| Rheumatic Fever | YES | NO | Allergy to Latex | YES | NO | Yellow Jaundice | YES | NO |
| Arthritis | YES | NO | Allergies or Hives | YES | NO | Epilepsy or Seizures | YES | NO |
| Rheumatism | YES | NO | Sinus Trouble | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Pain in Jaw Joints | YES | NO | Radiation Therapy | YES | NO | Phen-Fen | YES | NO |
| Cortisone Medicine | YES | NO | Chemotherapy | YES | NO | Psychiatric Treatment | YES | NO |
| | | | | | | Drug Addiction | YES | NO |
6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____ YES NO
7. Do your ankles swell during the day? _____ YES NO
8. Do you use more than two pillows to sleep? _____ YES NO
9. Have you lost or gained more than 10 pounds in the past year? _____ YES NO
10. Do you ever wake up from sleep and feel short of breath? _____ YES NO
11. Are you on a special diet? _____ YES NO
12. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO
13. Do you have or have you had any disease, condition, or problem not listed? _____ YES NO
- If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) _____

and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (19% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____